COVID-19 REGISTRATION FORM

PATIENT INFORMATION

Date of Registration/ Time	Last Name	First Name	Middle Name	Date of Birth
SSN#	Age	Birth Sex (circle one) Male / Female	Transgender? Male to Female / Female to Male	
Address / Apt#			City, State, Zip	
Home Phone	Work Phone	Employed ☐ No ☐ Yes	Employer Name Address: ______ Phone #: ______	
Patient Email Address		Race: ☐ Black ☐ White ☐ Asian, Native American Pacific Islander	Ethnicity: ☐ Hispanic ☐ Non-Hispanic	

INSURANCE INFORMATION

Primary Insurance Plan	Primary Policy # / Group #	Primary Subscriber Name / DOB
Secondary Insurance Plan	Secondary Policy # / Group #	Secondary Subscriber Name / DOB

EMERGENCY CONTACT INFORMATION #1

Last Name	First Name	Middle Name
Relationship to Patient	Cell Phone: Work Phone:	Email:

EMERGENCY CONTACT INFORMATION #2

Last Name	First Name	Middle Name
Relationship to Patient	Cell Phone: Work Phone:	Email:

FOR OFFICE USE ONLY

PLEASE CHECK ALL THE APPLY:

☐ SOCIAL SECURITY NUMBER: ______________________

☐ STATE OF RESIDENCE: ______________

VERIFIED ☐ FLORIDA DRIVERS LICENSE OR STATE ISSUED ID: ______________________

☐ OTHER: ______________

INSURANCE STATUS

☐ INSURED VERIFIED ☐ UNINSURED

PLAN NAME: ______________

ATTESTATION

I ATTEST THAT I HAVE ATTEMPTED TO CAPTURE ALL REQUIRED INFORMATION (SSN AND STATE OF RESIDENCY OR DRIVERS LICENSE/STATED ISSUED ID AT THE TIME OF SERVICE. LEASE CHECK ALL THE APPLY: LEASE CHECK ALL THE APPLY: ALL INFORMATION NOT CAPTURED. ☐

PRINT NAME OF C4U OFFICE STAFF	SIGNATURE OF C4U OFFICE STAFF	DATE

CARE 4 U
COMMUNITY HEALTH CENTER
"Because We Care!"

GENERAL CONSENT FOR TREATMENT, RELEASE OF MEDICAL INFORMATION AND AUTHORIZATION FOR INSURANCE/SELF PAYMENT

1. I, the undersigned or legal guardian grant permission as indicated below to undergo all necessary tests, treatments and other procedures or studies required for the diagnosis by my medical staff and other employees of C4U Community Health Center.

2. I am aware that the practice of medicine surgery is not exact science and I acknowledge that no guarantees have been made to me as a result of treatment and examination by C4U Community Health Center.

3. I consent to the release of medical information to other institutes or agencies accepting the patient for medical or institutional care, and consent to the release of the medical information to patient's insurer and give permission to release data (both medical and personal) to such government agencies as is required of C4U Community Health Center.

4. I consent to the release of medical and financial information for auditing purposes.

5. I hereby authorize payment to C4U Community Health Center of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS, otherwise payable to me, but not to exceed the health center and/or physician's regular charges for this period of treatment. I agree that a copy of this authorization is as valid as the original. I understand that if my insurance does not approve the charges for the visit, I am fully responsible to C4U Community Health Center for payment.

6. **MEDICARE PATIENTS ONLY**: I authorize any holder of medical or other information about me to release to Centers for Medicare and Medicaid (CMS) or its intermediaries or carriers, any information needed for this or any subsequent Medicare claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party that accepts assignment for such claim.

7. BY SIGNING THIS DOCUMENT, I ATTEST THAT ALL INFORMATION IS TRUE AND CORRECT AND WILL NOTIFY C4U COMMUNITY HEALTH CENTER OF AND CHANGES TO MY INSURANCE INCOME OR CONTACT INFORMATION.

PRINT NAME OF PATIENT OR LEGAL GUARDIAN	SIGNATURE OF PATIENT OR LEGAL GUARDIAN	DATE